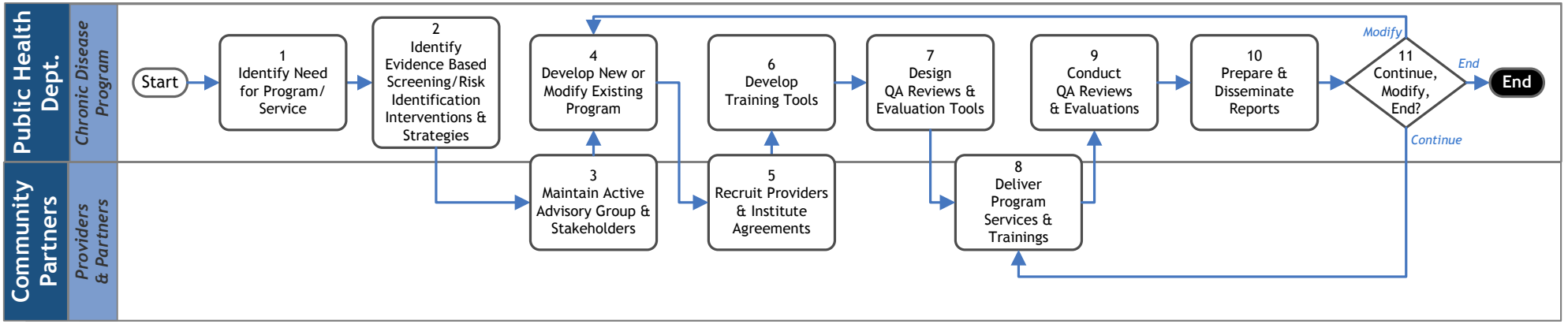
Screening and/or Risk Identification

Draft 10/19/09

Common Ground
Missouri Chronic
Disease Programs



Activity Details / Narrative

General Process Notes

- Community Partners include health service providers, hospitals, social and professional organizations, local and county governments, etc.
- Triggers include a change in the prevalence and incidence of a chronic disease revealed by routine surveillance or through foundation, legislative or executive interest.
- **BP: Program Administration** provides overarching guidance and management of administrative details for every program from first tasks through last.

1. Identify Need for Program/Service

- **BP: Disease Status and Burden Assessment** may generate a report that documents a chronic disease and/or risk factor problem for which a service or program is needed.
- Strategic planning may initiate a program or service to address a long standing chronic disease problem in a population.

2. Identify Evidence Based Screening or Risk Identification Interventions & Strategies

- Review and select the evidence based interventions and their implementation strategies available to address the identified disease or risk factor problem.

3. Maintain Active Advisory Group & Stakeholders

- An advisory committee comprised of community partners, chronic disease experts and DHSS staff should be empanelled and consulted regularly to provide guidance on program delivery.
- **BP: Partner Mobilization** Local partners may also be needed to help market the program's services to better target potential participants.

4. Develop New or Modify Existing Program

- If there is an existing program or service that meets the need for the chronic disease or risk factor of concern, then determine if there are adequate resources to fulfill the program or service.
- If there is not an existing program or service that meets the need for the chronic disease or risk factor of concern, then develop a new program or service.
- Developing a new program involves many rounds of testing and refinement before widespread adoption.

5. Recruit Providers & Institute Agreements

- Developing a program delivering interventions to communities will require recruiting of local providers and instituting contractual agreements.

6. Develop Training Tools

- Develop training curriculum for a new chronic disease program to the needs of services provided.

7. Design QA Reviews & Evaluation Tools

- Metrics for the process and program outcomes are defined so services can be evaluated for level of ongoing achievement of provider and program objectives.
- Data collection infrastructure and analytic methods are identified and implemented using **BP: Data Management and BP: Program Evaluation**.

8. Deliver Program Services & Trainings

- Infrastructure for delivering chronic disease programs and services to the targeted populations are provided.
- Efforts of partners and individuals in communities, and at DHSS, are coordinated by program.
- Case management services focus on early detection in high risk individuals.
- Program staff ensures ongoing collection of data for program evaluation.
- Conduct training with the adopted curriculum.

9. Conduct QA Reviews & Evaluations

- **Inputs: BP: Data Management and BP: Program Evaluation.** Previously defined metrics measure the success of services and achievement of targeted outcomes.
- Providers are evaluated using the program data and data collected onsite from charts.
- The program is evaluated using collected data.

10. Prepare and Disseminate Reports

- QA reports are shared with providers on an ongoing basis.
- Progress reports are shared with community and state stakeholders, partners and leaders, in coordination with the Communications Department.

11. Continue, Modify or End Program?

- Based upon the evaluation results, funding and timelines determine whether program continues, needs major modifications or ends altogether.